

Welcome to the e PREP provider portal page!

1. New providers/ groups enrolling with Maryland Medicaid for the first time will need to create a user profile. In order to begin this process, please click the “Sign Up” hyperlink shown below:

Best viewed in: Chrome

Welcome to ePREP!
Let's Sign in

Username

E-mail address


Don't have a User Profile? [Sign Up](#) [Next](#)

WARNING!

You have accessed Maryland Medicaid's Internal Test Site - **NOT** Intended For Public Use
Applications submitted from this environment **WILL NOT** be processed by Maryland Medicaid.

To access Maryland Medicaid's Public Site [CLICK HERE](#)

2. On this page, you will enter your personal information (first and last name), create a username, password and fill in all corresponding information followed by selecting the “Next” button when completed.



Welcome to ePREP!

My name is Lucy. I'm here to help you create your ePREP User Profile. This profile allows you to securely login to the ePREP Portal at any time (24/7) from an up-to-date web browser: Chrome, Firefox, Safari, IE Explorer.

Let's get started!

First name

Last name

Username


Password


Confirm

Phone number


Recovery email address

This reCAPTCHA is for testing purposes only. Please report to the site admin if you are seeing this.

 I'm not a robot



reCAPTCHA
[Privacy](#) - [Terms](#)

By selecting Next, you agree to the [Terms and Conditions](#).

Best viewed in:  Chrome

NEXT

3. In an attempt to increase security measures within the portal, please determine how you would like to receive your authentication code - once you have made your selection, please click 'Next'.



We have increased our security levels and need to **verify** your device.

Choose an [option below](#) to receive your security code.

Once you receive the code, you will enter it here in ePREP before you can login.

☒ Send text message to my phone number


☐ Call my phone number

☐ Send to my recovery email address

BACK

NEXT

4. Please enter your 6 digit authentication code and click "Verify".




I'm sending you the verification code to this location. This code will expire in 90 minutes. This code can only be generated up to 5 times within a 24 hour period.

The verification code has been sent to your [Phone Number](#):


(410) .

ePREP- Enter 6 digit Verification Code

[BACK](#) [CALL INSTEAD](#) [VERIFY](#)



You did it!

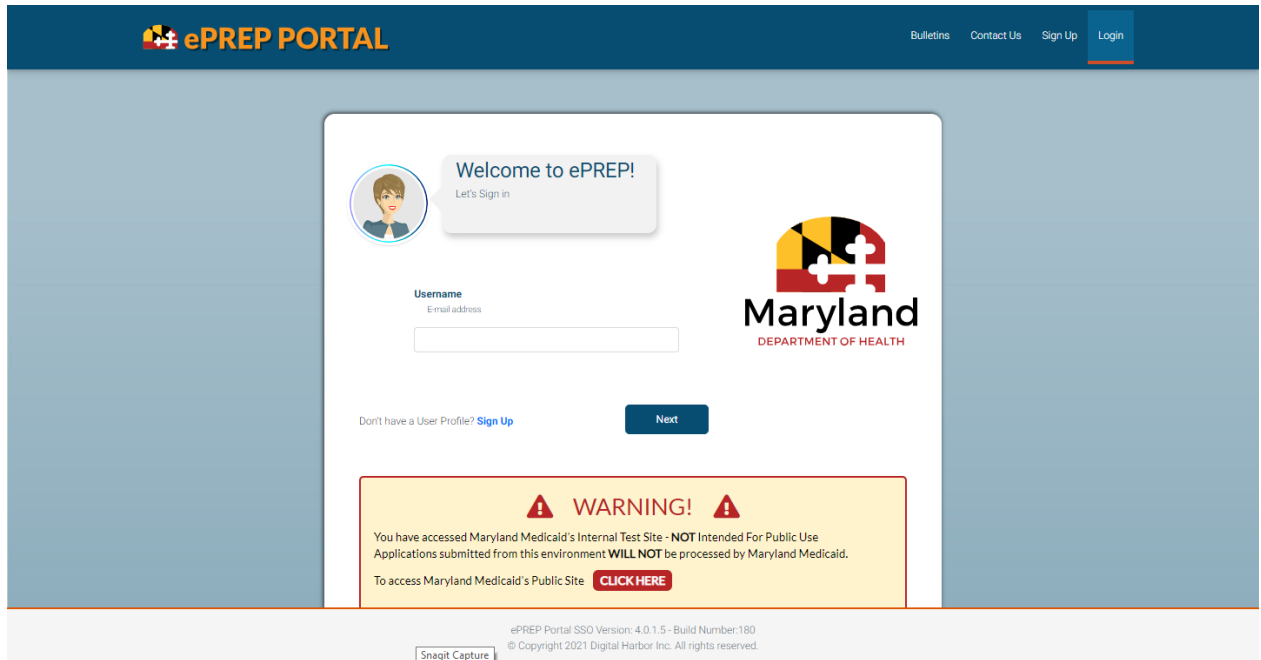


Success

Select [Login](#) to continue

[LOGIN](#)

5. Once you have successfully entered and verified your security code, users will need to login for the first time with your username (email address) and password. Both of which were entered and created in the steps above.



The image shows the ePREP PORTAL login interface. At the top, there is a dark blue header with the ePREP PORTAL logo on the left and navigation links (Bulletins, Contact Us, Sign Up, Login) on the right. The main content area is white and features a 'Welcome to ePREP!' message with a 'Let's Sign in' link. Below this is a 'Username' field with a placeholder 'Email address'. To the right of the field is the Maryland Department of Health logo. A 'Next' button is located below the field. A warning box with a red border and exclamation marks states: 'WARNING! You have accessed Maryland Medicaid's Internal Test Site - NOT Intended For Public Use. Applications submitted from this environment WILL NOT be processed by Maryland Medicaid. To access Maryland Medicaid's Public Site, CLICK HERE.' At the bottom, there is a footer with version information and a 'Snagit Capture' watermark.

ePREP PORTAL

Bulletins Contact Us Sign Up Login

Welcome to ePREP!
Let's Sign in

Username
Email address

Next

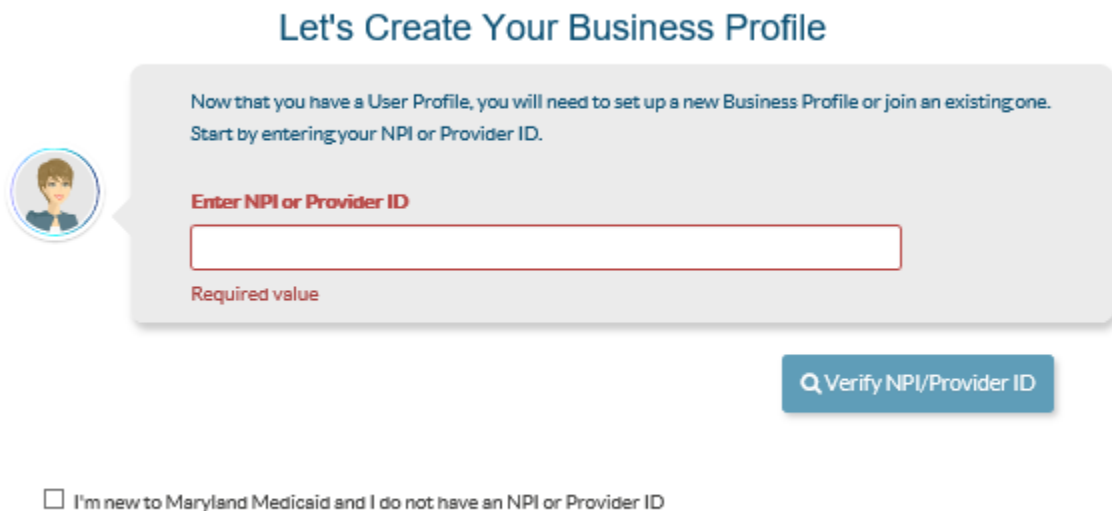
Don't have a User Profile? [Sign Up](#)

WARNING!
You have accessed Maryland Medicaid's Internal Test Site - **NOT** Intended For Public Use
Applications submitted from this environment **WILL NOT** be processed by Maryland Medicaid.
To access Maryland Medicaid's Public Site [CLICK HERE](#)

ePREP Portal SS0 Version: 4.0.1.5 - Build Number:180
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Snagit Capture

6. Once you have entered your credentials, you will be asked to create your business profile. In order to do this, you must first enter and verify your NPI number.



The image shows the 'Let's Create Your Business Profile' screen. It features a blue header with the title 'Let's Create Your Business Profile'. Below the title is a message: 'Now that you have a User Profile, you will need to set up a new Business Profile or join an existing one. Start by entering your NPI or Provider ID.' To the left of the message is a circular profile picture of a woman. Below the message is a red-bordered input field with the placeholder text 'Enter NPI or Provider ID'. Below the field is a red label 'Required value'. To the right of the field is a blue button with a magnifying glass icon and the text 'Verify NPI/Provider ID'. At the bottom, there is a checkbox with the text 'I'm new to Maryland Medicaid and I do not have an NPI or Provider ID'.

Let's Create Your Business Profile

Now that you have a User Profile, you will need to set up a new Business Profile or join an existing one.
Start by entering your NPI or Provider ID.

Enter NPI or Provider ID

Required value

Verify NPI/Provider ID

☐ I'm new to Maryland Medicaid and I do not have an NPI or Provider ID

7. Once you have entered and verified your NPI, the provider ID box will turn green and you will be able to enter the provider / group name you are attempting to enroll.

****This is the name that will be listed on your provider business profile.****

8. Security questions portion: please select and correctly answer three corresponding security questions as they pertain to you. Once you have completed this portion, you will be able to continue moving forward through the business profile creation process by selecting “Next”.

****It's important to note that sometimes these security questions are bypassed and are able to be completed later in the enrollment process****

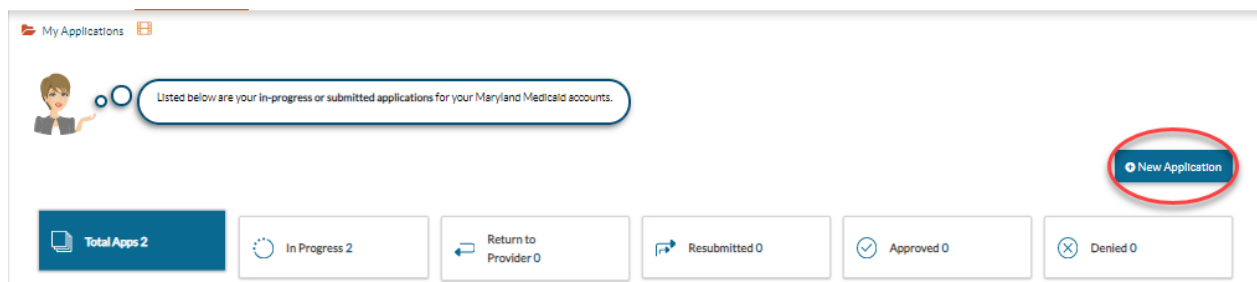
9. Once your business profile has been created, you will be taken to the e PREP home page

shown below:



10. From here, please click the “My Applications” tab / or building with the “My Applications” heading attached shown above.

11. Once you have successfully entered the “My Applications” tab, you will need to create a new application in order to enroll your provider type with Maryland Medicaid. **Circled in the screenshot below.**




12. Application generation: one you have clicked the “New Application” tab, the following selection will need to take place in order to generate your enrollment application.

13. **Application Generation Selection:** please make the selections listed below:

- I'm new to Maryland Medicaid, and I want to create a new application
- I'm an Individual health care practitioner




- Please select the Solo Practitioner or Rendering provider option based on your pay-to status. Once selected, please select continue.



Great! Now select which business structure best fits you as a health care Individual provider.

☐ I'm a Solo Practitioner

☐ I'm a Rendering Provider 

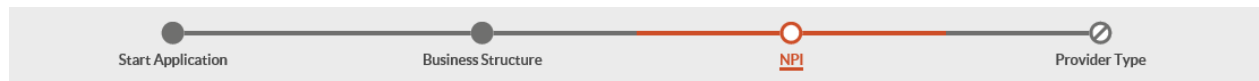
☐ I'm an Ordering/Referring/Prescribing (ORP) provider

Required value

Once you have made your choice, select **Continue**

[< Previous](#) [Continue >](#)

- Once you have entered your NPI, please click the “verify” option. Once the NPI has been verified, the NPI box will turn green and you will be able to successfully continue through the application generation process.



Okay, you have chosen Individual Solo Practitioner for your application. Please enter your Type 1 **National Provider Identifier (NPI)** that you want to use for this application, and select **Verify**.

National Provider Identifier (NPI)

Required value

Verify >

When you have entered and verified your NPI, select **Continue**.

< Previous

Continue >

- **Provider type** - in the drop down box menu, please select the provider type **Doula** and click continue.

Start Application Business Structure NPI **Provider Type**

Now that your NPI has been verified, select your Group's **Provider Type** from the drop-down list, and press **Continue** to move on.

Provider Type

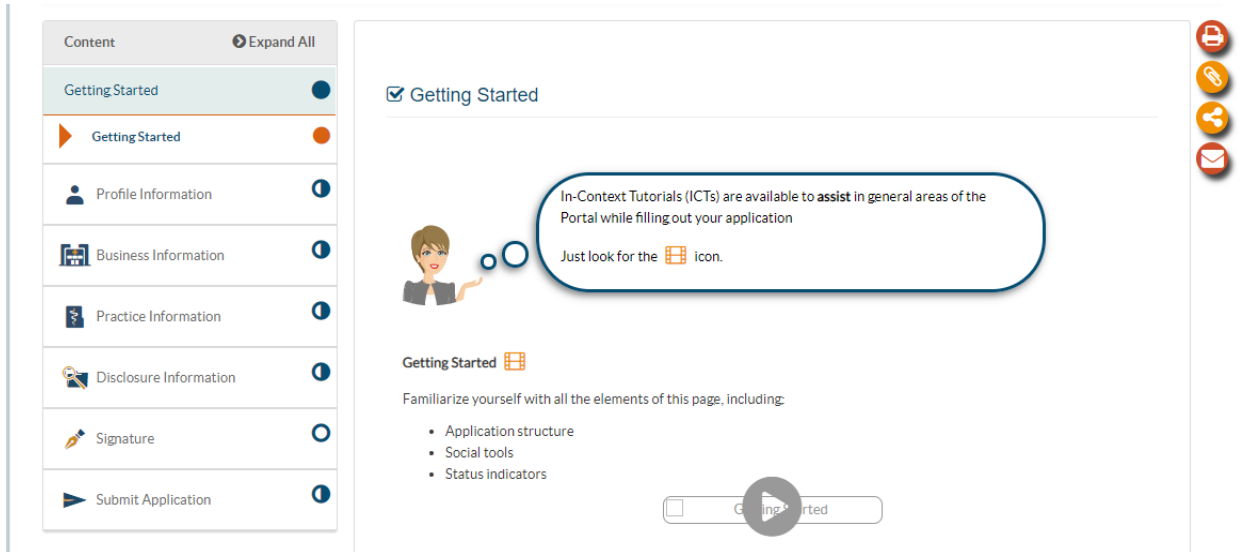
DOULA ▼

When you are ready, select **Continue**.








< Previous

Continue >

14. Successful Application Generation - Once you have generated the application, you will be able to complete each required section from start to submission.



15. As you navigate the application, this side bar will indicate your progress. A fully shaded circle denotes a finished section, while a half shaded circle signifies an incomplete section. Example shown below:

Content		Expand All
Getting Started		<input checked="" type="radio"/>
	Getting Started	<input type="radio"/>
	Business Information	<input type="radio"/>
	Practice Information	<input type="radio"/>
	Disclosure Information	<input type="radio"/>
	Rendering Provider Affiliations	<input type="radio"/>
	Signature	<input type="radio"/>
	Submit Application	<input type="radio"/>

16. **Profile Information:** Please enter all provider information into the corresponding data fields within this section.

Content

Expand All

Getting Started

Profile Information

Individual Profile

Business Information

Practice Information

Disclosure Information

Signature

Submit Application

Personal Information

Identification

Summary

Please take a few minutes to fill out some personal information to continue with your application.

Prefix

<Select a Prefix>

First name

Middle name

Last name

Suffix

<Select a Suffix>

Professional title

<Select a Professional Title>

Gender

<Select a Gender>

Required value

Date of birth

17. Business Information:

Content

Expand All

Getting Started

Profile Information

Business Information

Business Profile

Contact Person

Addresses

Logistics

Practice Information

Disclosure Information

Signature

Submit Application

TIN/EIN & Business License

Summary

I need some additional information about your business.
Please attach clear copies of your documentation.

☒ Please use my Social Security Number (SSN) since I don't have a Federal Tax Identification Number (TIN).

SSN

State Department of Assessment and Taxation (SDAT) number

N/A

Required value

Does your business use a registered Doing Business As (DBA) name?

☐ Yes
 ☐ No

Required value

Please enter your SSN into the corresponding data field. Additionally, all individuals who are enrolling with Maryland Medicaid are required to obtain and disclose their SDAT number. Please do not select “N/A” as the application will be returned to you to provide this information.

Should you have a DBA name, please select “Yes”, and attach the supporting documentation. If you do not have a DBA, please select “No” and click continue.

The screenshot shows a web form with a blue header bar. The main content area is white. At the top, there is a question: "Does your business use a registered Doing Business As (DBA) name?" with radio buttons for "Yes" (selected) and "No". Below this is a text input field for "DBA name" with a "Required value" error message. Underneath is a section for "Doing Business As (DBA) statement" with a dashed box containing a cloud upload icon and the text "Drag and drop here or [browse](#) 50MB Maximum". Below this are three text input fields: "Business number", "Extension", and "Website's URL" (with a "practice" label next to it). At the bottom are two buttons: "Previous" (with a left arrow) and "Continue" (with a right arrow).

18. **Contact Person Information:** Please be sure to fill out the contact information correctly. The contact person should be the managing employee of the application. If there are any questions regarding the application, this person will be the direct contact person.

Getting Started

Profile Information

Business Information

Business Profile

Contact Person

Addresses

Logistics

Practice Information

Disclosure Information

Signature

Submit Application

Contact Person Information

Summary

Who should I contact if I have questions about your application?
Please choose a contact person who will be available during regular business hours.

☐ I, [redacted] will be the contact person

First name

Last name

Title/Position

Business number

Extension

Fax Number

Correspondence email address

Previous

Continue

19. Please fill out the service address portion of the application:

1

Service Address

2


Pay-to Address

3

Mailing Address

4

Summary



Your Maryland Medicaid account is based on the location where health care services will be provided. As you type, a suggested address will appear that can auto-fill the rest of the form for you. Remember that a P.O. box cannot be used as a service address.

[View Address](#)

Street

Address Line 1

Required value

Ste. / Apt. #

Suite/Apt

City

City

Required value

State/Province

Maryland, MD

County

County

Required value

ZIP Code/Postal Code

96819-4000

Is this service location ADA (American Disabilities Act) accessible?

☐ Yes ☐ No

Required value

Does this service location have TTY capability?

☐ Yes ☐ No

Required value

Previous

Continue

20. Please answer the following 'Yes' or 'No' questions:

Is this service location ADA (American Disabilities Act) accessible?

☐ Yes ☐ No

Required value

Does this service location have TTY capability?

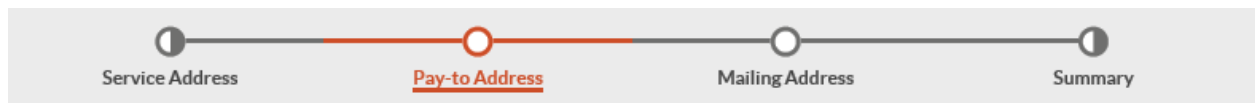
☐ Yes ☐ No

Required value

← Previous

Continue →

21. Please fill out the Pay to Address of the location. (If you are not registered for EFT, this is the address the payment will be sent to.)



Please let me know the address where you want to receive payments.

☐ Same as Service address

[View Address](#)

Street

Address Line 1

Required value

Ste. / Apt. #

Suite/Apt

City

City

Required value

State/Province

<Select a State>



Required value

County

County

Required value

ZIP Code/Postal Code

ZIP Code/Postal Code

Required value

[← Previous](#)

[Continue →](#)


22. Please fill out the Mailing Address for the location. If there is a specific person that needs correspondence, please identify them. Please say: **ATTN:LAST NAME, FIRST NAME**

Service Address

Pay-to Address

Mailing Address

Summary



Last step! Add a mailing address where you want receive official Maryland Medicaid correspondence.

☐ Same as Service address

[View Address](#)

Street

Address Line 1

Required value

Ste. / Apt. #

Suite/Apt

City

City

Required value

State/Province

<Select a State>

Required value

County

County

Required value

ZIP Code/Postal Code

ZIP Code/Postal Code

Required value

Previous

Continue

23. **Logistics:** Please answer the following ‘Yes’ or ‘No’ questions:

24. What are the business hours for this business location?

- If you are open 24/7, please check the box.
- If you are a business that has specific hours of operation, please list them here.

What are the business hours for this service location?

- ☐ Open 24/7
☐ Open on specific business days/hours

Required value

25. Has the individual listed on this application completed cultural competency training?
Please answer ‘Yes’ or ‘No’.

Has _____ completed a cultural competence training? ☐ Yes ☐ No

Required value

26. Is the individual accepting new patients? Please answer 'Yes' or 'No' as it pertains to your business.

Is _____ accepting new patients? ☐ Yes ☐ No

Required value

27. What is the age range of the patients that will be treated at this service location?

What is the age range of the patients that will be treated at this service location? ☐ Enter age range ☐ All ages

Required value

28. Does the individual see fee-for-services (FFS) Medicaid participants?
Please answer 'Yes' or 'No' as it pertains to your organization.

Does _____ see fee-for-service (FFS) Medicaid participants? ☐ Yes

☐ No, I only accept HealthChoice managed care patients

Required value

29. Does the individual provide language services to their patients, other than English, at this location? If "Yes," please list all other languages in this section.

Does _____ provide language services to their patients, other than English, at this location? ☐ Yes ☐ No

Required value

30. Once you have completed filling out all of the Business Information, the circle will be completely filled in.

Content	Expand All
Getting Started	●
Business Information	●

31. Practice Information Section:

Please disclose all applicable licenses and certifications in this section of the application:

Content

Expand All

Getting Started

Profile Information

Business Information

Practice Information

Licenses & Certifications

NPI/Taxonomy/Specialty

Disclosure Information

Signature

Submit Application

Individual Licenses & Certifications

Summary

Here you can attach your professional licenses and certificates. Make sure you provide clear copies so my analysts can read them. Be sure to start with your most important license: Let's start with the license from your professional board that allows you to provide health care services. If you are a nurse practitioner or nurse midwife, start with your registered nurse license.

State health care license number

Health Care State License

Drag and drop here or browse

50MB Maximum

Issuance State/Province

Issuance date

Expiration date

Is required to have copies of other specialized Licenses or Certifications from the appropriate board or authority?

☐ Yes
☒ No

Examples of acceptable Doula Certifications:



CHILDBIRTH
INTERNATIONAL
training without boundaries

This is to certify that

Student Name

has completed a course of instruction
and met the requirements for

Birth Doula Certification

and is now entitled to use the letters

CBD (CBI)

Graduate ID: XXX-#####

Signed on this day dd Month YYYY



Nikki Macfarlane
Founder & Managing Director
Childbirth International



CHILDBIRTH
INTERNATIONAL
training without boundaries

This is to certify that

Student Name

has completed a course of instruction and met the
requirements for

Postpartum Doula Certification

and is now entitled to use the letters

CBD (CBI)

Graduate ID: XXX-#####

Signed on this day dd Month YYYY



Nikki Macfarlane
Founder & Managing Director
Childbirth International



35 E. Wacker Drive, Suite 850
Chicago, IL 60601-2106 USA
www.DONA.org

Be It Hereby Known That

#1111

Certified Birth Doula

has successfully completed the Birth Doula Certification Program of
DONA International, is permitted to use credentials CD(DONA), and is thereby
qualified to offer professional labor support, following DONA International
Standards of Practice, to birthing families.

Certification is contingent on continuous membership in DONA International.

3/31/2024

Expiration

Director of Certification



35 E. Wacker Drive, Suite 850
Chicago, IL 60601-2106 USA
www.DONA.org

Be It Hereby Known That

#1111

Certified Postpartum Doula

has successfully completed the Postpartum Doula Certification Program of DONA International, is permitted to use credentials PCD(DONA), and is thereby qualified to offer professional postpartum support, following DONA International Standards of Practice, to families with newborn babies.

Certification is contingent on continuous membership in DONA International.

3/31/2024

Expiration

Director of Certification

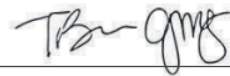
Doula Trainings International

Jane Doe, CD (DTI)
certified full-spectrum doula

dti

September 28 2021

date



founders

CERTIFICATE OF ATTENDANCE

This temporary certificate is awarded to

as proof that the above has completed the 12 hour course and has earned the
credentials as a

CERTIFIED PREGNANCY & CHILDBIRTH DOULA(BDI)

BDI#2021-60

Given on this 25th day of April, 2021 at the International Black Doula Institute

Nikita Johnson SM. COBST. CDBAD.

NIKITA JOHNSON
CEO/Director, BDI

April 25, 2023

Certificate Expiration



The International Childbirth Education Association

hereby certifies that

Name, ICPD

has satisfactorily completed the requirements of the

ICEA Postpartum Doula Certification Program

and maintains the title of

ICEA Certified Postpartum Doula

2 January 2020

Date

31 January 2023

Expiration Date

Jenna Westheimer

Certification Program Coordinator



The International Childbirth Education Association

hereby certifies that

Name, ICBID

has satisfactorily completed the requirements of the

ICEA Birth Doula Certification Program

and maintains the title of

ICEA Certified Birth Doula

2 January 2020

Date

31 January 2023

Expiration Date

Jenna Westheimer

Certification Program Coordinator



Mamatoto Village, Inc. Certificate of Completion

recognizes that

has successfully completed the requirements to be certified as a

Community Birth Worker

The program awarded the following credits: 45.0 contact hours

Date

Aza Nedhari, LM, CPM, MS,
Executive Director

Mamatoto Village, Inc.

Certificate of Attendance

recognizes that

has successfully completed the following educational session:

Perinatal Health Worker Training

The program awarded the following credits: 192.0 contact hours

Date



Aza Nedhari, LM, CPM, MS,
Executive Director

32. **NPI/ Taxonomy/ Specialty:** Please double check that the NPI listed on this page is correct.

- a. The Taxonomy code should match what is in NPPES
- b. If the individual has any additional specialty codes, please list them here.

Business Information

Practice Information

Licenses & Certifications

NPI/Taxonomy/Specialty

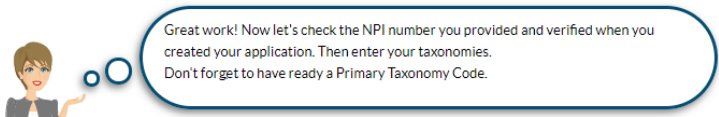
Additional Information

Disclosure Information

Rendering Provider Affiliations

Signature

Submit Application



Great work! Now let's check the NPI number you provided and verified when you created your application. Then enter your taxonomies. Don't forget to have ready a Primary Taxonomy Code.

National Provider Identification (NPI)

Associated Taxonomy Codes

+ Add

Description	Taxonomy Code	Type	Actions
No taxonomy code listed.			

Associated Specialty Codes

☐ N/A

+ Add

Specialty Code	Description	Type	Actions
No Specialty code listed.			

33. Please list the associated taxonomy code. This taxonomy code is listed in NPPES and was given to you when you first registered for the NPI.

Add Taxonomy Code

Taxonomy code

<Select a value>

Required value

Type

☒ Primary
 ☐ Secondary

+ Add

✕ Cancel

created your application. Then enter your taxonomies.

Business Information

Practice Information

Licenses & Certifications

NPI/Taxonomy/Specialty

Additional Information

Disclosure Information

Rendering Provider Affiliations

Signature

Submit Application

Great work! Now let's check the NPI number you provided and verified when you created your application. Then enter your taxonomies. Don't forget to have ready a Primary Taxonomy Code.

National Provider Identification (NPI)

Associated Taxonomy Codes

Description	Taxonomy Code	Type	Actions
Doula	374J00000X	Primary	

Associated Specialty Codes

☐ N/A

Specialty Code	Description	Type	Actions
No Specialty code listed.			

34. Addenda/ Supporting Documents - Please be sure to attach the Medical Assistance Program Application. **Provider Type DL - Doula** is the correct addenda needing to be attached to this section of the application.

Addenda/Supporting Documents

Summary

The provider type Local Education Agencies/Local Lead Agency **requires** addenda and supporting documents to be **attached to this application**.

Select **Addenda/Supporting Documents** to select the required addenda and supporting documents. Once you have completed the required attachments select the Add button.

☐ N/A

Addenda/Supporting Document Name

Documents

Actions

There is no addenda

Previous

Continue

You can find the needed Addendum by going to the Maryland Medicaid website or by clicking on the following link and downloading the Addendum:

<https://health.maryland.gov/mmcp/Pages/Provider-Enrollment.aspx>

Addendum Example:



**Addendum for Maryland
Medical Assistance Program Application
PROVIDER**

Doula/Birth worker - PT DL

If you have questions, please contact the Provider Enrollment Helpline at 1-844-4MD-PROV (1-844-463-7768)
Monday – Friday from 7am – 7pm.

All providers are required to use the electronic Provider Revalidation and Enrollment Portal, or ~~ePREP~~
(eprep.health.maryland.gov) for enrollment, information updates, provider affiliations and revalidations.

Individual Doula Attestation Form. Please fill out the information below and upload the completed addendum to the
“Additional Information” section under “Practice Information” within the ~~ePREP~~ (eprep.health.maryland.gov)
“Applications” tab, along with any additional documents requested within the addendum.

Date of Attestation Submission: __/__/__

Attestation of Certification [Check the applicable organization, making sure that you have every certification listed for that organization.]

- ☐ Ancient Song Doula Services
 - ☐ Full Spectrum Labor & Postpartum Certification
- ☐ Childbirth International (CBI)
 - ☐ Birth Doula Certification
 - ☐ Postpartum Doula Certifications
- ☐ The Childbirth and Postpartum Professional Association (CAPPA):
 - ☐ Certified Labor Doula
 - ☐ Certified Postpartum Doula
 - ☐ Certified Community Lactation Educator Certification
- ☐ Doulas of North America (DONA)
 - ☐ Birth Doula Certification
 - ☐ Postpartum Doula Certification
- ☐ Doula Trainings International:
 - ☐ Full Spectrum Doula Certification
 - ☐ OR (Birth Doula Certification and Postpartum Doula Certification)
- ☐ The International Black Doula Institute (IBDI):
 - ☐ Pregnancy & Childbirth Doula Certification,
 - ☐ Postpartum & Newborn Certification
 - ☐ Lactation/Breastfeeding Certificate of Completion
- ☐ International Childbirth Education Association (ICEA)
 - ☐ Birth Doula Certification
 - ☐ Postpartum Doula Certification
- ☐ ~~Mamatoto~~ Village
 - ☐ Community Birth Worker Certification
- ☐ ~~MaternityWise~~:
 - ☐ Labor Doula Certification
 - ☐ Postpartum Doula Certification



**Addendum for Maryland
Medical Assistance Program Application
PROVIDER**

Doula/Birth worker - PT DL

Attestation of Doula Program Certification [Check all that apply]

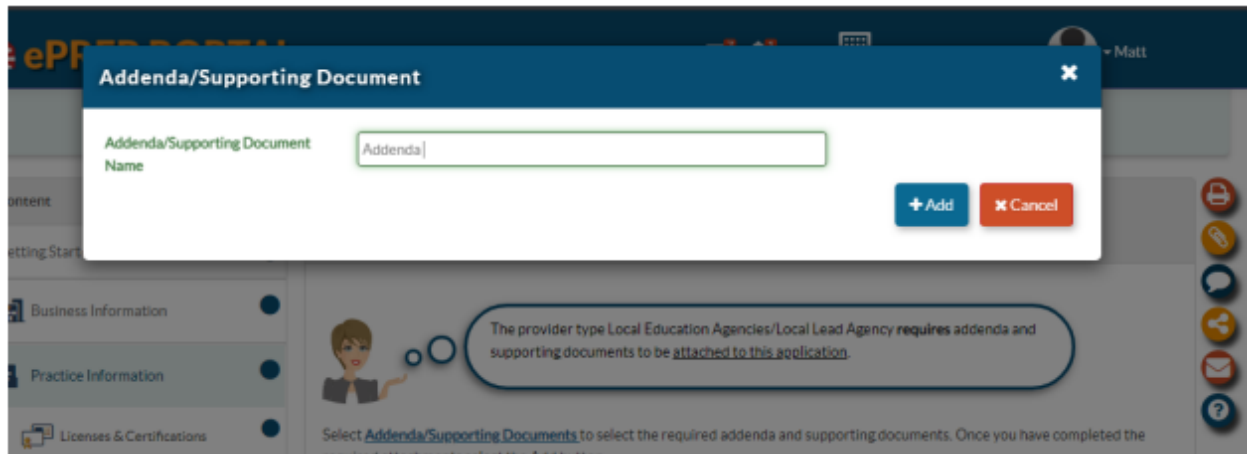
- ☐ The individual attests that they have obtained the certification checked above, and has attached documentation from the certifying organization.
- ☐ The individual attests that they will notify Maryland Department of Health (MDH) of any change in certification status within 30 days.

Attestation of Liability Insurance [Check one]

- ☐ Yes, I have adequate liability insurance.
- ☐ No. If no, please attach explanation.

Attestation of Fingerprint Criminal Background Check Completion

- ☐ I understand that all doula providers have passed a Fingerprint Criminal Background Check (FCBC).



35. Please click on the 'Add' button to name the Addendum.

Upload Document



Drag and drop here, or [Select your file ...](#)

File size can not be greater than 50 MB

Please note that in order for your document to be reviewed, you must remove any passwords that have been used to keep it secure.

Section Name

Addenda/Supporting Documents

Document Name

Title

Required value

Description

☒ Share it in Document Library.

☒ This is a sensitive document.


Attach

Cancel

36. Please click 'Add' again to upload the Addendum.

Addenda/Supporting Documents

Summary






The provider type Local Education Agencies/Local Lead Agency **requires** addenda and supporting documents to be attached to this application.

Select [Addenda/Supporting Documents](#) to select the required addenda and supporting documents. Once you have completed the required attachments select the Add button.

☐ N/A

Add

Addenda/Supporting Document Name	Documents	Actions
Facility/ Organization	<div>  <div> Addenda/Supporting Document </div> <div>document is required</div> </div>	 

Previous

Continue

37. Once the Addendum is uploaded, please click continue.

38. **Adverse Action:** Please fill out any adverse action information.

Profile Information

Business Information

Practice Information

Disclosure Information

Adverse Actions

Fines and Debts (Gov.)

Subcontractors

Control Interest

Significant Transactions

Delegated Officials

Signature

Submit Application

Now please provide information about any adverse actions as specifically asked in the following questions with a **clear copy of each requested document**. This information must be accurate, complete and true to the best of your knowledge and belief.

Has been terminated, denied enrollment, suspended, restricted by Agreement or otherwise sanctioned by the Medicaid program in Maryland or in any other State, Medicare, or any governmental or private medical insurance program?

☐ Yes
☒ No

Has ever been convicted of a crime related to the furnishing of, or billing for, medical care or supplies or which is considered an offense against public administration or against public health and morals in any State?

☐ Yes
☒ No

Has ever been found liable for fraud or abuse involving a government program in any civil proceeding?

☐ Yes
☒ No

Has ever entered into a settlement to resolve a proceeding related to fraud or abuse involving a government program?

☐ Yes
☒ No


Has ever had their business or professional license or certification suspended, surrendered, or in any way restricted by probation or agreements by any licensing authority in the state?

☐ Yes
☒ No

39. Once you have completed the adverse action page, please click continue. Please fill out any fines or debts that the organization has. If the organization has none, please check the box shown in the screenshot below:

Fines and Debts (Gov.)

Summary



If you have any fines or debts to any organization related to Medicare, Medicaid or any other federal or state health care programs, please let me know of your payment arrangements.

☐ This business has no current State or Federal government Fines/Debts

Add

Type	Agency Name	Amount	Date Issued	Date to be Paid-in-full	Documents	Actions
No Fines/Debts listed						

×

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Continue →

40. If you are a Solo practitioner, please answer the following questions as they pertain to your organization; If you are a rendering provider, this section will not populate on your application

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Subcontractors

Summary



Awesome, JULIE KARNER! This part is even simpler. It's related to any subcontractors you may or may not have.

Does have any subcontractors to which the applicant has contracted or delegated some of its management functions or responsibilities of providing healthcare services, equipment, or supplies or with whom the applicant has entered into a contract, agreement, purchase order, lease, or leases of real property, to obtain space, supplies, equipment, or services provided under the Maryland Medicaid Program?

☐ Yes ☐ No

Required value

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Continue →

41. This is the Ownership/ Control Interest page. Should your organization have a controlled interest component, please click 'Add.'

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Control Interest Summary

Please let me know about any individuals who have control interest in your practice.

Are there any Individuals who have Control Interest in [redacted]?

All board members, corporate officers, directors, agents, and managing employees of [redacted] must be reported in this section as well.

☐ This business has no current individuals with Direct or Indirect Control Interest

+ Add

Type	Name	Control Interest	Status	Actions
No Ownership Control Interest listed.				

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Add Ownership/Control Interest

☐ Entity ☐ Individual

Required value

+ Add X Cancel

41. Please identify if the organization is owned by an entity or an individual.

Add Ownership/Control Interest



☐ Entity ☒ Individual

First name

Required value

Middle name

Last name

Required value

+ Add

✕ Cancel

42. With either the entity or individual, please identify their name.

Profile Information	Please enter the following information
Business Information	First name <input type="text" value="Allyson"/>
Practice Information	Middle name <input type="text"/>
Disclosure Information	Last name <input type="text" value="League"/>
Adverse Actions	Social Security Number <input type="text" value="--- --"/>
Fines and Debts (Gov.)	Date of birth <input type="text" value="--/--"/>
Subcontractors	Age <input type="text"/>
Control Interest	National Provider Identification (NPI) <input type="checkbox"/> N/A
Significant Transactions	Primary Residence Address
Delegated Officials	View Address
Signature	Street <input type="text" value="Address Line 1"/>
Submit Application	Ste. / Apt. # <input type="text" value="Suite/Apt"/>
	City <input type="text" value="City"/>
	State/Province <input type="text" value="Select a State"/>
	County <input type="text" value="County"/>
	ZIP Code/Postal Code <input type="text" value="ZIP Code/Postal Code"/>

Does Allyson League currently participate or has ever participated as a provider in the Maryland Medicaid program or in another states' Medicaid program? ☐ Yes ☐ No

Required value

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43. Please select the appropriate choice for the individual listed in controlled interest of the application:

The screenshot shows a web application interface with a sidebar menu on the left and a main content area on the right. The sidebar menu, titled 'Content' with an 'Expand All' button, lists various sections: 'Getting Started', 'Profile Information', 'Business Information', 'Practice Information', 'Disclosure Information' (highlighted), 'Adverse Actions', 'Fines and Debts (Gov.)', 'Subcontractors', 'Control Interest' (highlighted with an orange dot), 'Significant Transactions', 'Delegated Officials', 'Signature', and 'Submit Application'. The main content area features a progress bar at the top with five steps: 'Individual Information', 'Control Interest' (active), 'Association', 'Adverse Actions', and 'Summary'. Below the progress bar, the text reads 'Please select one or more of the options that apply to Allyson League'. There are five checkboxes with corresponding labels: 'Board Member', 'Managing Employee', 'Agent', 'Director/Officer', and 'Other'. Each checkbox is followed by a small 'x' icon. At the bottom of the form, there are two buttons: 'Previous' and 'Continue'.

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Individual Information **Control Interest** Association Adverse Actions Summary

Please select one or more of the options that apply to Allyson League

☐ Board Member

☐ Managing Employee

☐ Agent

☐ Director/Officer

☐ Other

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44. Please answer 'Yes' or 'No' to the following questions about the ownership entity or individual.

	Individual Information	Control Interest	Association	Adverse Actions	Summary
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Practice Information					
Disclosure Information					
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Associations/Family relations with subcontractors and owners of subcontractors

Ownership of 5% or more on any subcontractor

Does Allyson League have ownership with any of [redacted] subcontractors disclosed in this application? ☐ Yes ☐ No Required value

Family Relations with subcontractor or subcontractor's owner(s)

Does Allyson League have family relations with any of [redacted] subcontractors disclosed in this application? ☐ Yes ☐ No Required value

Does Allyson League have any family relations with any owner(s) of [redacted] subcontractors? ☐ Yes ☐ No Required value

Associations/Family Relations with Individuals (owners/control interest of Applicant)

Is Allyson League affiliated with any Entities or is family related to any Individuals disclosed in this application? ☐ Yes ☐ No Required value

Other Associations

Does Allyson League have any ownership or Control Interest in any other health care provider participating or not participating in Maryland Medicaid? ☐ Yes ☐ No Required value


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45. This is the 'Significant Transactions' page. Please mark 'yes' to the following question.

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Significant Transactions

Summary



Please carefully read this question and answer accordingly.

I, , agree that upon request by the Secretary of the Maryland Department of Health, or the Maryland Department of Health, full and complete information will be supplied within 35 days of the date of request, concerning:

☐ Yes ☐ No

Required value

A. The ownership of any subcontractor with which the Title XIX Provider has had, during the previous 12 months, business transactions in an aggregate amount in excess of \$25,000.00 and

B. Any significant business transactions, occurring during the 5 year period ending on the date of such request, between the provider and any wholly-owned supplier or subcontractor.

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Delegated Officials

Summary

Here's where you can designate all Delegated Officials for your health care business.

A Delegated Official is either 1) an individual with ownership/control interest or 2) a W-2 employee (not a contractor) to whom you wish to give authorization to sign Affiliate applications on behalf of your Group or Organization.

Adding a Delegated Official is optional. If you choose not to add one, that means only your Group/Organization's authorized individuals may sign Affiliate applications.

☐ I do not want to report any Delegated Officials at this time.

Add

Legal Name	Reported by	Added Date	Last Update	Status	Actions
No Delegated Officials listed.					

☐ A DELEGATED OFFICIAL means an individual who is delegated the authority to sign on behalf of the applicant or provider by an authorized official for situations as specified in the provider bulletin titled Requirements and Procedures for Groups Designating Delegated Officials. The delegated official must be an individual with ownership or control interest in, or be a W-2 Employee of, the provider or applicant. An independent contractor cannot be a delegated official.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the entity's Maryland Medicaid enrollment information. The authorized official will still retain the authority to make changes and/or updates, even if a delegated official is appointed.

A provider or applicant is not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make changes and/or updates to enrollment information.

Signatures provided by delegated officials shall have the same force and effect as that of an authorized official, and shall legally and financially bind the provider or applicant to the laws, regulations, provider bulletins and program instructions of the Maryland Medicaid program.

By his or her signature on affiliation forms, a delegated official certifies that the individual has read the Maryland Medicaid Provider Agreement, and all information in the affiliation form and agrees to adhere to all the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official as defined in provider bulletin titled Requirements and Procedures for Groups Designating Delegated Officials. The delegated official certifies under penalty of.

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46. Please identify any delegated officials.

47. If there are no organizational affiliations, please click 'No.'

48. If the organization does have affiliations, please click 'Yes' and add any needed information.

50. Once onto the signature portion, please fill out the required information and click submit.

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Declarations

E-Signature

Summary

You're almost ready to sign your application!

Even though you're completing and submitting your application through ePREP Portal and not on paper, your signature is still required. Using the electronic signature feature, you can submit this application just like your handwritten signature.

Please read the Maryland Medicaid Provider Agreement, and then check the boxes to declare that you agree with this process.

Please note that in order to continue with the e-Signature process, you must read the Provider Agreement.

[Maryland Medicaid Provider Agreement](#)

☒ I, Allyson League, have read, understood, and agree with the terms of the Maryland Medicaid Provider Agreement.

☒ I, Allyson League, declare that I have legal authorization to sign this application for and on behalf of MDH HOME VISITING SERVICES.

☒ I, Allyson League, have reviewed my application and believe all information and attachments are correct to the best of my knowledge.

☒ I, Allyson League, declare under penalty of perjury under the laws of Maryland that the foregoing information and the information on all attachments is true, accurate and complete, to the best of my knowledge and belief, and that I am authorized to sign this application pursuant to State Regulations.

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Declarations

E-Signature

Summary

To continue with the e-Signature process, I need to verify your personal information.

After agreeing to the declaration, make sure your Social Security Number and Date of Birth are identical to what you entered in the Personal Information section of the Ownership/Control Interest sub-form.

Please treat this section the same way as if you were using your PIN at an ATM.

If you need help with this section, please watch this In-Context Tutorial about e-signing a Facility application.

☒ I, Allyson League, agree that my electronic signature is attributable as defined in Commercial Law Article § 21-208.

SSN (last 4 digits)

###-##-____

Required value

Year of birth

##/##/____

Required value

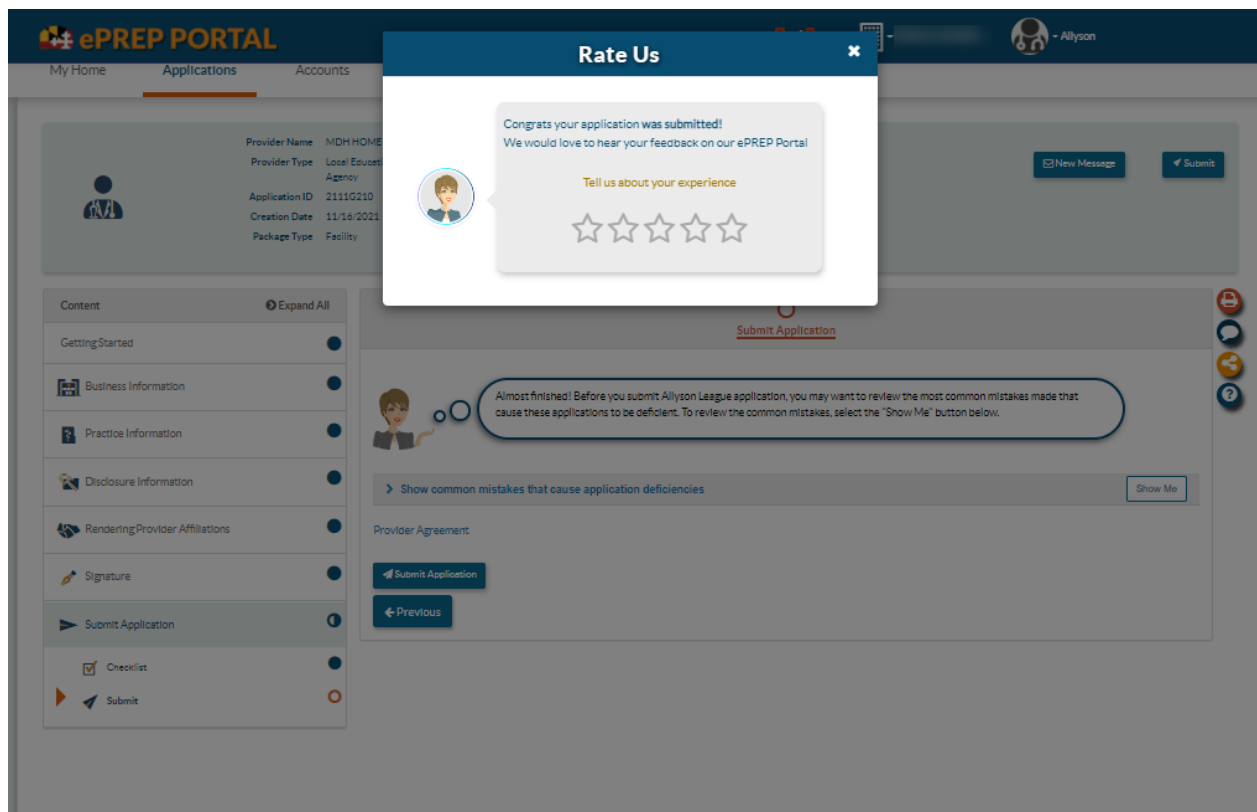
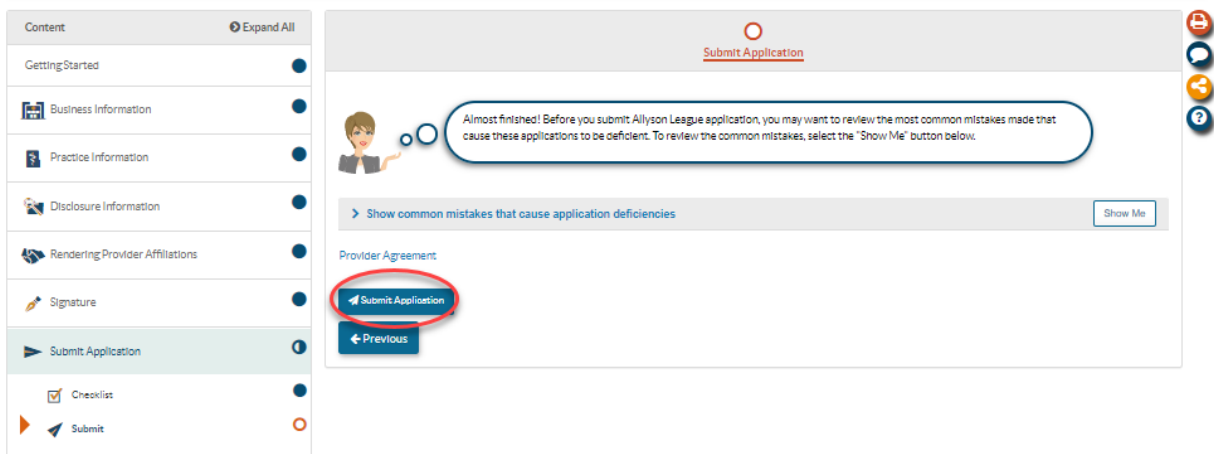
Email address

allyson.league@maryland.gov

Password

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Please feel free to rate the ePREP system and leave any comments that pertain to your application submission.

Thank you for your time.

If you have any questions, please contact us at

mdh.providerenrollment@maryland.gov